Vermont Department of Banking, Insurance, Securities and Health Care Administration

Rule No. H-2007-05

Health Care Price and Quality Transparency Rule

Section 1. Purpose.

The purpose of this Rule is to provide consumers with access to information concerning health care prices, health care quality, and other information necessary to empower consumers, including uninsured consumers, to make economically sound and medically appropriate decisions.

Section 2. Authority.

This Rule is issued pursuant to the authority vested in the Commissioner by law, including but not limited to 18 V.S.A. § 9410(a)(2), 8 V.S.A. § 15(a), and 18 V.S.A. § 9404(d).

Section 3. Definitions.

As used in this Rule:

(1) "Brand Name Drug" means a drug marketed under a proprietary, trademark-protected name.

(2) "Charge" means the amount sought as payment by a Health Care Facility, Health Care Provider, or seller of prescription drugs, durable medical equipment, or medical supplies for a health care service or product before the application of any discount, write-off, contract or plan adjustment or allowance, or other reduction to such amount.

(3) "Commissioner" means the Commissioner of the Department.

(4) "Consumer Information Plan" means the Consumer Information Plan filed by a Health Insurer for the benefit of the Health Insurer's Members, and approved by the Commissioner under Section 4 of this Rule.

(5) "Department" means the Vermont Department of Banking, Insurance, Securities and Health Care Administration.

(6) "Diagnostic Related Group" or "DRG" means any of the diagnostic categories which Medicare accepts that can be used to classify a patient's inpatient service for reimbursement purposes.

(7) "Generic Drug" means a drug which has been approved by the Food and Drug Administration as a generic drug to be equivalent to a Brand Name Drug in dosage, safety, strength, how it is taken, quality, performance, and intended use.

(8) "Health Care Facility" means all institutions, whether public or private, proprietary or nonprofit, which offer diagnosis, treatment, inpatient or ambulatory care to two or more unrelated persons, and the buildings in which those services are offered. The term shall not apply to any facility operated by religious groups relying solely on spiritual means through prayer or healing, but includes all institutions included in subdivision 9432(7) of Title 18, except health maintenance organizations.

(9) "Health Care Provider" means a person, partnership or corporation, other than a facility or institution, licensed or certified or authorized by law to provide professional health care service in this state to an individual during that individual's medical care, treatment or confinement, and, except in connection with the requirements of Section 6 of this Rule, practicing under a participating provider agreement with a Health Insurer.

(10) " Health Care Provider Practice" means an organization of Health Care Providers whose financial information is reported annually by a Hospital pursuant to 18 V.S.A. Chapter 221, subchapter 7.

(11) "Health Insurer" means:

(A) any health insurance company, nonprofit hospital and medical services corporation, or health maintenance organization with at least five percent of the lives covered in the insured market in Vermont, as reported by the Department for the prior calendar year. The requirements of this Rule apply to:

(i) a Health Insurer in connection with its insured plans;

(ii) a Health Insurer, or the controlled affiliate of a Health Insurer, acting as a third-party administrator for a health benefit plan, and

(iii) the agents or affiliates of the Health Insurer who contract to administer the benefits covered or administered by the Health Insurer, such as pharmacy benefit managers and mental health services review agents licensed under 8 V.S.A. § 4089a; and

(B) the employee health benefit plan offered by the State of Vermont, or any agency or instrumentality of the state; and

(C) Medicaid, VHAP, SCHIP and any other health benefit plan offered or administered by the Vermont Office of Health Access, to the extent permitted by federal law or authority.

(12) "Hospital" means an acute care hospital licensed under chapter 43 of Title 18, Vermont Statutes Annotated, and except for purposes of Section 6 of this Rule, any out of state hospital with more than 1,000 annual inpatient

discharges of Vermont residents. The Department shall publish annually a list of hospitals that satisfy the criteria of this subdivision.

(13) "Member" means an individual or dependent covered by the health benefit plan of a Health Insurer.

(14) "Physician" means a physician practicing under a participating provider agreement with a Health Insurer, except in connection with the requirements of Section 6 of this Rule.

(15) "Price" means the amount due to a Health Care Facility, Health Care Provider, or seller of durable medical equipment, or medical supplies for a health care service or product after the application of any discount, write-off, contract or plan adjustment or allowance, or other reduction to the Charge amount, and before the application of any individual Member cost-sharing, including deductibles, co-payments, co-insurance, and out-of-pocket maximums. The "Price" of prescription drugs means the amount due to the pharmacy or other entity for the delivery of prescription drugs to the Health Insurer's Members, or the pharmacy's or other entity's usual and customary charge, whichever is lower; provided that the Health Insurer may, but is not required to disclose the lower usual and customary charge.

(16) "Primary Care Physician" means a Physician who provides primary care services, and who is designated as a primary care physician by the Health Insurer.

(17) "Rule" means the administrative rule adopted herein.

(18) "Therapeutic Equivalent Drug" means drug products classified as therapeutically equivalent by the Food and Drug Administration that can be substituted with the full expectation that the substituted product will produce the same clinical effect and safety profile as the prescribed product.

(19) "Uninsured Consumer Information Plan" means the Uninsured Consumer Information Plan filed by a Hospital or by a Health Care Provider Practice and approved by the Commissioner under Section 6 of this Rule.

Section 4. Health Insurer Consumer Price and Quality Information Plans

(a) General. Each Health Insurer shall establish, maintain and administer a Consumer Information Plan approved by the Commissioner.

(b) Filing and Approval. On or before January 1, 2009, on or before January 1, 2011, and if required thereafter under subdivision (c)(4) of this Section, each Health Insurer shall file in writing with the Commissioner a Consumer Information Plan that complies with the requirements of this Rule. The Consumer Information Plan shall be deemed approved unless the

Commissioner, within 30 calendar days of filing, approves, disapproves, or approves the Consumer Information Plan subject to such conditions as the Commissioner may prescribe as necessary to ensure that the Consumer Information Plan is consistent with the provisions of this Rule, and with the provisions of 18 V.S.A. § 9410(a)(2). The Commissioner may extend the time period to review and act upon the Plan for one additional 30 day period if necessary. The Commissioner shall not disapprove a Consumer Information Plan unless the Commissioner finds that it is in noncompliance with one or more of the requirements of this Rule. The Consumer Information Plan shall take effect and be implemented six months after approval, unless the Health Insurer demonstrates and the Commissioner finds that a later effective date is needed to avoid undue financial or administrative burden. The Consumer Information Plan of a Health Insurer as defined by Section 3(11)(C) shall be deemed approved upon filing; however the Department may offer guidance to Plans filed by the Vermont Office of Health Access as is necessary and appropriate to carry out the purposes of this Rule.

(c) Phased-In Consumer Information Plan Price Information.

(1) First Phase. On and after October 1, 2008, each Health Insurer shall provide Members with a link on the Health Insurer's website to, or information on how to access, at least the information identified or described in the Department's Act 53 Hospital Community Report website for hospital quality and Charge information, and free care and discount policies.

(2) Second Phase. A Consumer Information Plan filed with the Commissioner on or before January 1, 2009 shall describe how the Health Insurer will provide consumers with Price information concerning at least the information identified or described in subdivisions (A) through (E), below.

(A) The in-patient, out-patient diagnostic and other procedures and services provided by each Hospital, as identified in the Act 53 Hospital Community Report pursuant to 18 V.S.A. § 9405b(c).

(B) The following procedures or services provided by individual Physicians or Physician practices:

(i) the list of procedures and services identified in Appendix A; or

(ii) an alternative list filed with the Commissioner, if the Commissioner determines that the alternative list will accomplish the purposes of this Rule. Such alternative list may include for Physician services and procedures a list approved by the Commissioner of 'examination and management' codes, plus the code for routine obstetrical care;

(C) The 100 prescription drugs most frequently prescribed to the Health Insurer's Members, not including prescription drugs administered by a

Health Care Provider in the office environment. Price information shall permit Price comparison of the list of most frequently prescribed drugs with those Brand Name Drugs, Therapeutic Equivalent Drugs, and Generic Drugs, which can be prescribed for a specific illness or condition, or for a category of illnesses or conditions. In counting the 100 most frequently prescribed drugs, a Brand Name Drug and its Generic Drug equivalent shall be counted as one drug, and different dosages of the same drug shall be counted as one drug. If a Health Insurer's Price for prescription drugs does not vary from pharmacy to pharmacy, the Health Insurer may disclose to Members that one Price applies for all pharmacies, and the Health Insurer need not list Price for individual pharmacies;

(D) The 20 items of durable medical equipment most frequently purchased or leased by the Health Insurer's Members; and

(E) The 10 items of medical supplies such as diabetic supplies, excluding any items obtained through the Health Insurer's pharmacy benefit manager's website most frequently purchased by the Health Insurer's Members.

(3) Third Phase. A Consumer Information Plan filed with the Commissioner on or before January 1, 2011 shall describe how the Health Insurer will provide consumers with Price information concerning at least the information identified or described in subdivisions (A) through (E) below.

(A) The in-patient, out-patient, diagnostic and other procedures and services provided by each Hospital, as identified in the Act 53 Hospital Community Report pursuant to 18 V.S.A. § 9405b(c).

(i) Where applicable to, and feasible for a specific Hospital in connection with inpatient procedures and services, Price information shall be aggregated for Hospital and Physician Price information for procedures and services typically associated with Diagnostic Related Group codes in a manner approved by the Commissioner upon consideration of the recommendations of the Act 53 Financial Workgroup.

(ii) Where applicable to, and feasible for a specific Hospital in connection with outpatient procedures and services, Price information shall be aggregated for Hospital and Physician Price information in a manner approved by the Commissioner upon consideration of the recommendations of the Act 53 Financial Workgroup.

(iii) The Health Insurer shall disclose to Members the methodology used to derive the Price for the Diagnostic Related Group.

(B) The following procedures or services provided by individual Physicians or Physician practices:

(i) The list of procedures and services identified in Appendix A; or an alternative list filed with the Commissioner, if the Commissioner determines that the alternative list will accomplish the purposes of this Rule.

(ii) Such alternative list may include for Physician services and procedures a list approved by the Commissioner of "examination and management" codes, plus the code for routine obstetrical care.

(iii) Such alternative list may also include a list approved by the Commissioner after consideration of an advisory committee of affected parties convened by the Department to assist in the development of filing instructions for Consumer Information Plans filed on or before January 1, 2011. The Commissioner may require Health Insurers to use a uniform or substantially uniform list of Physician procedures and services in the Health Insurer's Consumer Information Plan, if the Commissioner determines that a reasonable state-wide or national consensus has been reached with respect to the disclosure of Price information for Physician procedures and services;

(C) The 200 prescription drugs most frequently prescribed to the Health Insurer's Members, not including prescription drugs administered by a health care provider in the office environment. Price information shall permit comparison of the list of most frequently prescribed drugs with those Brand Name Drugs, Therapeutic Equivalent Drugs, and Generic Drugs, which can be prescribed for a specific illness or condition, or for a category of illnesses or conditions. In counting the 200 most frequently prescribed drugs, a Brand Name Drug and its Generic Drug equivalent shall be counted as one drug, and different dosages of the same drug shall be counted as one drug. If a Health Insurer's Price for prescription drugs does not vary from pharmacy to pharmacy, the Health Insurer may disclose to Members that one Price applies for all pharmacies, and the Health Insurer need not list Price for individual pharmacies;

(D) The 40 items of durable medical equipment most frequently purchased or leased by the Health Insurer's Members; and

(E) The 20 items of medical supplies, such as diabetic supplies, excluding any items obtained through the Health Insurer's pharmacy benefit manager's website most frequently purchased by the Health Insurer's Members.

(4) Fourth Phase. A Consumer Information Plan filed with the Commissioner on or before January 1, 2013, and every two years thereafter, shall describe how the Health Insurer will provide consumers with the following Price information:

(A) At least the information identified or described in subdivisions (3)(A) through (E), above;

(B) After consultation with affected parties, and with the approval of the Commissioner, Price information shall include an increase of the number of items disclosed of up to 400 prescription drugs, and up to 80 items of durable medical equipment, and up to 40 medical supply items; and

(C) after consultation with affected parties, and with the approval of the Commissioner by means of an order issued pursuant to 8 V.S.A. § 15, Price information concerning the following categories of care and treatment, if such care and treatment is covered by the Health Insurer: chiropractic, psychological and other mental health care and treatment, naturopathic, dental, physical therapy, osteopathic, nursing home, home health, and other care and treatment provided by Health Care Providers. A person aggrieved by an order issued under this subdivision may file an administrative appeal pursuant to BISHCA Regulation 82-1 (Revised), and the order appealed from shall be stayed as to the appellant until the final decision of the Commissioner is issued.

(D) Upon request of a Health Insurer, the Commissioner may waive or modify one or more requirements of this subdivision (4) if the Health Insurer demonstrates and the Commissioner finds that application of the requirement is unreasonable, unnecessary, or contrary to the purposes of this Rule.

(d) Phased-In Consumer Information Plan Quality Information.

(1) Hospital Quality Information.

(A) On and after October 1, 2008, each Health Insurer shall provide Members with a link on the Health Insurer's website to, or information on how to access the Department of Health and Human Services, or Centers for Medicare and Medicaid Services "Compare" websites for hospitals, nursing homes, home health agencies, and other Health Care Providers and Health Care Facilities for which similar information resources are developed in the future.

(B) In a Consumer Information Plan filed with the Commissioner on or before January 1, 2009, a Health Insurer shall use, or provide a link to the hospital quality information maintained pursuant to Act 53 to satisfy the Hospital quality information requirements of this Rule. In addition, the Health Insurer may use other Hospital quality measures approved by the Commissioner as valid and reliable, after consultation with affected parties.

(2) Physician Quality Information.

(A) In the Consumer Information Plan filed with the Commissioner on or before January 1, 2009, the Health Insurer shall describe how the Health Insurer will provide quality information at least with respect to Primary Care Physicians. In connection with such Plan, the Health Insurer shall use either:

(i) NCQA physician recognition certification to satisfy the Health Care Provider quality information requirements of this Rule. The Health Insurer shall not be obligated to secure, facilitate or promote NCQA physician recognition certification for Physicians, but shall report on whether the Physician has been certified by NCQA. The Health Insurer shall not be required to report that a Physician has not been certified by NCQA; or

(ii) quality measures approved by the Commissioner, after consultation with affected parties, as valid and reliable, or designated as 'nationally recognized' by the Commissioner, after consultation with affected parties. The Commissioner may prescribe terms and conditions in connection with any such approval or designation relating to the reliable and comprehensive use of such measures. The Commissioner may require Health Insurers to use uniform or substantially uniform quality measures if the Commissioner determines that a reasonable, national consensus has been reached with respect to uniform quality measures. The Commissioner shall designate as 'nationally recognized' those quality information and reporting measures endorsed by the Centers for Medicare and Medicaid Services, the National Quality Forum, or the Ambulatory Quality Alliance. The Commissioner, after consultation with affected parties, may designate other nationally recognized quality information and reporting measures.

(B) In the Consumer Information Plan filed with the Commissioner on or before January 1, 2011, the Health Insurer shall describe how the Health Insurer will provide quality information with respect to Primary Care Physicians and with respect to other Physicians. In connection with such Plan, the Health Insurer shall use both:

(i) NCQA physician recognition certification to satisfy the Health Care Provider quality information requirements of this Rule with respect to Primary Care Physicians and with respect to other Physicians. The Health Insurer shall not be obligated to secure, facilitate or promote NCQA physician recognition certification for Physicians, but shall report on whether the Physician has, or has not been certified by NCQA; and

(ii) quality measures approved by the Commissioner, after consultation with affected parties, as valid and reliable, or designated as 'nationally recognized' by the Commissioner, after consultation with affected parties. The Commissioner may prescribe terms and conditions in connection with any such approval or designation relating to the reliable and comprehensive use of such measures. The Commissioner may require Health Insurers to use uniform or substantially uniform quality measures if the Commissioner determines that a reasonable, national consensus has been reached with respect to uniform quality measures. The Commissioner shall designate as 'nationally recognized' quality information and reporting measures

those measures endorsed by the Centers for Medicare and Medicaid Services, the National Quality Forum, or the Ambulatory Quality Alliance. The Commissioner, after consultation with affected parties, may designate other nationally recognized quality information and reporting measures.

(3) The Health Insurer may elect to not provide quality information for particular procedures and services performed by an individual Physician, or by a Hospital if the number of procedures or services performed by such individual Physician or Hospital is too small to be statistically significant; and in such circumstances, the Commissioner may approve a Health Insurer's proposed use of alternative means of obtaining statistically significant quality measures.

(4) A Consumer Information Plan filed with the Commissioner on or before January 1, 2013, and every two years thereafter, shall describe how the Health Insurer will provide consumers with the following quality information:

(A) at least the information identified or described in subdivisions (d)(1) and (2), above;

(B) after consultation with affected parties, and with the approval of the Commissioner by means of an order issued pursuant to 8 V.S.A. § 15, quality information concerning the following categories of care and treatment, if disclosure of Price information with respect to such categories of care and treatment is required under Section 4(c)(4)(C) of this Rule, and if such care and treatment is covered by the Health Insurer: chiropractic, psychological and other mental health care and treatment, naturopathic, dental, physical therapy, osteopathic, nursing home, home health, and other care and treatment provided by Health Care Providers. A person aggrieved by an order issued under this subdivision may file an administrative appeal pursuant to BISHCA Regulation 82-1 (Revised), and the order appealed from shall be stayed as to the appellant until the final decision of the Commissioner is issued; and

(C) the reporting of Price and quality information together in a manner that identifies or describes the relative value of procedures, services, prescription drugs, and major medical equipment and medical supplies.

(D) Upon request of a Health Insurer, the Commissioner may waive or modify one or more requirements of this subdivision (4) if the Health Insurer demonstrates and the Commissioner finds that application of the requirement is unreasonable, unnecessary, or contrary to the purposes of this Rule.

(e) General Content Requirements. A Consumer Information Plan shall state the manner in which the Health Insurer will comply with the following

requirements during the period of time for which the Consumer Information Plan is applicable:

(1) The Health Insurer shall permit Members to view, by means of the Health Insurer's website, the Price for a particular Hospital, Physician, pharmacy, or other entity of the procedures, services, prescription drugs, and major medical equipment and supplies identified in the Health Insurer's Consumer Information Plan, or the median Price if there is a range of Prices. The Health Insurer shall permit Members to compare Prices and median Prices among specific Hospitals, Physicians, pharmacies and other entities.

(2) Price information shall be updated at least annually, and when Hospital, Physician, pharmaceutical, or other seller contracts are issued or reissued.

(3) If the Price for a particular procedure, service, prescription drug, item of medical equipment, or medical supply varies depending upon the different reimbursement rates of different Health Insurer products, the Health Insurer shall disclose the different Prices associated with the different products of the Health Insurer.

(4) During the First Phase of reporting, the Health Insurer has the option to use a link on the Health Insurer's website to the website of the applicable government agency to access the information required by subdivision (c)(1) of this Section, or to provide access to such information on the Health Insurer's own website.

(5) The Health Insurer may use a link on the Health Insurer's website to the website of the Health Insurer's pharmacy benefit manager for reporting of prescription drug information required by subdivisions (c)(2)(C), (c)(3)(C), and (c)(4) of this Section, or medical supplies purchased through the pharmacy benefit manager.

(6) The Health Insurer shall provide Members with guidance on how to estimate their out-of-pocket costs (including co-payments, coinsurance, and deductibles) for the procedures, services, prescription drugs, and major medical equipment and supplies identified in the Health Insurer's Consumer Information Plan. Upon request the Health Insurer shall provide Members assistance with estimating out-of-pocket costs. A Health Insurer shall not be required to provide on-line calculators to estimate out-of-pocket costs, provided that any alternative method offers adequate guidance to Members for estimating out-of-pocket costs.

(7) The Health Insurer shall permit Members, by means of the Health Insurer's website, to view and compare quality of care among specific Hospitals and Health Care Providers, in accordance with subsection (d) of this Section,

for the procedures and services identified in the Health Insurer's Consumer Information Plan.

(8) The Health Insurer shall establish for Members alternative mechanisms other than a website for obtaining the Price and quality information required by this Rule, such as through a toll-free telephone number available during normal business hours, or by providing printed price and quality information.

(9) The Health Insurer shall disclose to Members the source or sources of Price and quality information, information relating to reliability and reporting period for the Price and quality information provided in accordance with the Consumer Information Plan. The Health Insurer may communicate to Members suitable provisions disclaiming responsibility for the reliability and accuracy of the Price and quality information provided under the Consumer Information Plan.

(10) A Health Insurer may request that the Commissioner permit the substitution of one or more of the procedures, prescription drugs, or durable medical equipment and supplies for which Price information would be otherwise provided if the Health Insurer demonstrates and the Commissioner finds that the availability of price information would have anticompetitive consequences detrimental to consumers.

(11) Upon request by a Health Insurer, the Commissioner may waive one or more requirements of this Rule if the Health Insurer demonstrates and the Commissioner finds that application of the requirement is unreasonable, unnecessary, or contrary to the purposes of this Rule.

(12) The Health Insurer shall establish a procedure for Health Care Providers to review the Price and quality information related to the Health Care Provider, and to comment on its accuracy. The Health Insurer shall promptly correct inaccuracies where warranted. The Health Insurer shall maintain records of such comments, the Health Insurer's response to such comments, and corrections for five years, in accordance with Department Regulation 99-1 (Record Retention).

Section 5. Security Measures

A Health Insurer may establish and maintain security procedures for limiting access to the Health Insurer's Price and other information to Members only, through the on-line submission of a user name and password, or through some other Member verification and security procedure described in the Consumer Information Plan and approved by the Commissioner.

Section 6. Consumer Charge and Quality Information for Uninsured Consumers

(a) Each Hospital and Health Care Provider Practice shall establish, maintain, and administer an Uninsured Consumer Information Plan that is approved by the Commissioner, and that complies with the requirements of this Rule. The Uninsured Consumer Information Plan shall be deemed approved unless the Commissioner, within 30 calendar days of filing, approves, disapproves, or approves the Uninsured Consumer Information Plan subject to such conditions as the Commissioner may prescribe as necessary to carry out the purposes of 18 V.S.A. § 9410(a)(2). The Commissioner may extend the time period to review and act upon the Plan for one additional 30 day period if necessary. The Uninsured Consumer Information Plan shall take effect and be implemented six months after approval, unless the Hospital or Health Care Provider Practice demonstrates and the Commissioner finds that a later effective date is needed to avoid undue financial or administrative burden. The Uninsured Consumer Information Plan shall be filed with the Commissioner on or before January 1, 2009. The Hospital quality and charge information shall be updated annually, and when relevant charge and other changes are made.

(b) A Hospital Uninsured Consumer Information Plan shall provide, or describe a mechanism for consumers to access the following information, and to seek additional information and assistance in understanding Hospital quality and Charge information:

(1) Hospital quality information. A Hospital shall use the hospital quality information maintained pursuant to Act 53 to satisfy the hospital quality information requirements of this Rule. In addition, a Hospital may use Hospital quality information approved by the Commissioner under Section 4(d)(1)(B);

(2) Hospital Charge information, accompanied by:

(i) free care and discount policies;

(ii) eligibility criteria, the application process, and toll-free numbers for public health insurance programs such as Medicaid, VHAP, and Catamount Health Premium Assistance; and

(iii) information on how to access the Prescription Drug Price Finder of the Vermont Attorney General's Office; and

(3) A mechanism for a consumer to learn the estimated Charge for a specific in-patient, out-patient or diagnostic procedure or service offered by the Hospital.

(c) A Health Care Provider Practice Uninsured Consumer Information Plan shall provide or describe a mechanism for consumers to access the following information:

(1) Health Care Provider quality information. A Health Care Provider Practice shall use NCQA physician recognition certification for reporting on Health Care Provider quality. The Health Care Provider shall not be obligated by this Rule to secure NCQA physician recognition certification. In addition, a Health Care Provider Practice Uninsured Consumer Information Plan may use Health Care Provider quality information approved by the Commissioner under Section 4(d)(2)(B). The Commissioner may require the use of additional quality information and reporting standards and protocols approved under Section 4(d)(2)(B)(ii) as a condition of approval of an Uninsured Consumer Information Plan.

(2) Health Care Provider Practice Charge information, accompanied by free care and discount policies; and

(3) A mechanism for any uninsured patient of a Health Care Provider Practice to learn the estimated Charge for a specific health care procedure or service offered by the Health Care Provider Practice.

(d) Upon the request of any uninsured patient of a Health Care Provider, a Health Care Provider shall inform the patient of the estimated Charge for a specific health care procedure or service offered by the Health Care Provider, and shall inform the consumer of the provider's free care and discount policies, if any.

Section 7. Effective date.

This Rule shall take effect on October 1, 2008.

Health Care Price and Quality Transparency Rule - Appendix A

CPT Code	ervice Units	CPT Code Descriptions	Plain English Descriptions
Anesthesia			
00790		Anes Intraperitoneal Inc Shunts; Nos	Anesthesia for upper abdominal procedures
00840		Anes Intraperitoneal Low Abd; Nos	Anesthesia for lower abdominal procedures
01967		Neuraxial Labor Analgesia/Anesthesia For Planned V	Epidural obstetric anesthesia
Surgery			
11100	1,030	BX SKIN/SUBQ TISS (SEP PRO); 1 LES	Skin biopsy
17000	1,985	DESTRCT-ANY METHD-BEN LES; W/ANE; 1	Destruction of a single skin lesion
17003	2,452	DESTRCT-ANY METHD-BEN LES; 2-14, EA	Destruction of multiple skin lesions
20610	755	ARTHROCENTESIS/ASPIR/INJ; MAJOR JT	Aspiration or injection of a major joint
36415	33,713	ROUTINE VENIPUNCT/FINGER/HEEL STICK	Obtaining a sample of blood
45378	858	COLONOSCOPY FLEX; DX (SEP PRO)	Colonoscopy
45385	541	COLONOSCOPY FLEX; W/REMOV LES-SNARE	Colonoscopy with removal of lesion
Radiology			
71010	5,150	RADIOLOGIC EXAMINATION, CHEST; SINGLE VIEW, FRONTAL	Chest X-ray (single view)
71020	10,715	X-Ray Chest, Two Views, Frontal and Late	Chest X-ray (two views)
76083		Cmpt-Aided Detect Phys Rev for Intepr; Scr Mammo	Computer aided reading of a screening mammogram
76092		Screening Mammography, Bilateral	Screening Mammography
Laboratory/Pathology			
80061	2,128	LIPID PANEL	Cholesterol and lipid testing
81000	3,554	UA DIPSTIK/TABLET; NON-AUTO W/MICRO	Microscopic and chemical urine testing
81002	20,968	Urinalysis DIP STIK/TABLT;WO MICRO NON-AUTO	Chemical urine testing only
81025	6,754	URINE PREGNANCY TEST,BY VISUAL COLOR COMPARISON METHODS	Pregnancy test (urine)
82270	2,823	BLD OCCULT; FECES 1-3 SIMULT DETERM	Stool blood test
83036	652	HGB; GLYCATED	Hemoglobin A1C blood test
85018	7,656	BLD CT; HGB	Hemoglobin test
85025	1,347	Bld Cnt;hemo/Plt,Auto,Cmplt Dif.Wbc	Complete blood count (CBC)
85610	756	PROTHROMBIN TIME	Blood clotting test (prothrombin time)
87880	13,625	AGT-IMMUNASSAY DIR OBS; STREP GRP A	Strep test, group A
88305	12,421	LEVEL IV-SURG PATH GROSS/MICRO EXAM	Level IV surgical pathology examination
Medicine - Immunizations			
90465	4,399	IMMUNIZATION ADMINISTRATION UNDER 8 YEARS OF AGE (INCLUDES PERCUTANEOUS, INTRADERMAL, SUBCUTANEOUS, OR INTRAMU	Childhood immunization administration
90471	39,995	IMMUNIZATION ADMINSTRATION	Immunization administration
90472	24,662	Immunization administration two or more single or	Administration of multiple immunizations
90658	11,121	INFLUENZA VIRUS VACCINE	Influenza virus vaccine
90718		Tetanus and diptheria toxoids for intramuscular or	Tetanus and diptheria vaccines
90772	6,760	THERAPEUTIC, PROPHYLACTIC OR DIAGNOSTIC INJECTION	Any injection
Medicine - Mental Health Visits			
90805	6,787	PSYCHOTHER OP 20-30 MIN; W/MED E&M	Psychotherapy 20-30 minutes with medical evaluation
90806	19,194	PSYCHOTHER OV/OP-BEHV MOD 45-50 MN;	Psychotherapy 45-50 minutes
90807	12,085	PSYCHOTHER OP 45-50 MIN; W/MED E&M	Psychotherapy 45-50 minutes with medical evaluation
90853	21,982	GROUP MEDICAL PSYCHOTHERAPY (OTHER THAN OF A MULTIPLE-FAMILY GROUP) - ONE UNIT = 15 MINUTES	Group Psychotherapy 15 minutes
90862	9,187	PHARM MGMT W/SCRIPT USE & REVIEW	Management of psychiatric medications
Medicine - Eye & Ear Exams			
92004	1,319	Opthalmalogical exam; new patient, intermediate	Eye examination,new patient, intermediate amount of time
92012	2,690	OPHTH SERV: MED EXAM; INTERM ESTAB	Ophthalmological services intermediate established patient
92014	4,835	OPHTH SERV: MED EXAM; COMP ESTAB PT	Ophthalmological services comprehensive exam established patient
92015	6,838	DETERM REFRACTIVE STATE	Eye refraction determination
92567	4,246	TYMPANOMETRY	Middle ear test (tympanometry)
Medicine - Non-Invasive Vascular Studies			
93000	3,621	ECG-ROUTINE 12 LEAD; W/INTRPT & RPT	Electrocardiogram (EKG)
93010	10,046	Ecg;interpretation & Report Only	Electrocardiogram reading and report only
94760	690	NONINVAS OXIMETRY-O2 SAT; 1 DETERM	Test of blood oxygen saturation
95004	8,967	Percut Tests W/Extrac Immed React #	Allergy testing
Physical Medicine - PT/Chiro Procedures			
95165	3,169	Professional Services Supervision Provisions Antig	Supervision of allergen preparation
97001	2,299	Physical Therapy Evaluation	Physical Therapy Evaluation
97010	6,403	App. Of Modality, hot or cold packs	Application of hot or cold packs
97012	1,302	Phys. Med, traction, mechanical	Mechanical traction
97014	2,945	Phys. Med - Electrical Stimulation (unattended)	Electrical stimulation
97032	7,313	Appl. Of modality, electrical stimulation (manual)	Electrical stimulation requiring constant provider attendance
97033	1,530	Phys.Med., iontophoresis	Iontophoresis requiring constant attendance

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CPT Code	ervice Unit	CPT Code Descriptions	Plain English Descriptions
97035	10,128	Constant attendance, ultrasound	Ultrasonic therapy requiring constant attendance
97110	21,980	Phys. Med,Tx,1 Area,30 Min,Ea.Vist;ther.Exerc	Therapeutic exercises (15 minutes)
97112	9,442	Neuromuscular reeducation of movement, balance, coordination	Neuromuscular reeducation of movement, balance, coordination
97113	1,820	Aquatic Therapy w/exercises	Aquatic treatments with exercises
97140	14,991	Manual therapy (eg, mobilization/manipulation, manual lymphatic drainage, manual traction)	Manual therapy techniques
97530	2,381	Phys. Med. - Therapeutic/dynamic activities to improve function	Use of dynamic physical medicine treatments to improve function
98928	1,377	OSTEOPATH MANIP TX; 7-8 BOD REGIONS	Osteopathic manipulative treatments
98940	3,531	Chiro Manipulation, spinal, one or two regions	Chiropractice manipulation treatments
98941	20,216	Chiro, manipulation, spinal, three & four regions	Chiropractice manipulation treatments
98942	3,731	Chiro. Manipulation, spinal, five regions	Chiropractice manipulation treatments
98943	4,867	Chiro. Manipulation, extraspinal, one or more region	Chiropractice manipulation treatments
Medicine - Other Misc.			
99000	3,821	HANDL/CONVEY SPECMN-OFFIC TO LAB	Handling charge for lab specimen
99050	3,531	SERVICES REQUESTED AFTER OFFICE HOURS IN ADDITION TO BASIC SERVICE	After hour services
99173	5,174	SCREENING TEST OF VISUAL ACUITY, QUANTITATIVE, BILATERAL (USE W9020 WITH EPSDT MODIFIERS THRU DOS 06/30/02)	Eye sight testing (visual acuity)
Medicine - Acute Care Office & OPD Visits			
99202	8,257	OFFIC/OUTPT E&M NEW LOW-MOD 20MIN	Office visit, new patient,20 minutes
99203	12,213	OFFIC/OUTPT E&M NEW MOD SEVER 30MIN	Office visit, new patient, 30 minutes
99204	624	OFFIC/OUTPT E&M NEW MOD-HI 45 MIN	Office visit, new patient, 45 minutes
99211	12,667	OFFIC/OUTPT E&M ESTAB 5 MIN	Office visit, established patient, 5 minutes
99212	41,604	OFFIC/OUTPT E&M ESTAB MINOR 10MIN	Office visit, established patient, 10 minutes
99213	282,559	OFFIC/OUTPT E&M ESTAB LOW-MOD 15MIN	Office visit, established patient, 15 minutes
99214	96,989	OFFIC/OUTPT E&M ESTAB MOD-HI 25 MIN	Office visit, established patient, 25 minutes
99215	12,173	OFFIC/OUTPT E&M ESTAB MOD-HI 40 MIN	Office visit, established patient, 40 minutes
Medicine - Hospital Inpatient Services			
99231	5,813	SUBSQT HOSP-DA E&M STABLE 15 MIN	Follow up hospital visit 15 minutes
99232	13,987	Inpatient care - SUBSQT HOSP-DA E&M MINR COMPL 25MIN	Follow up hospital visit 25 minutes
99233	8,600	SUBSQT HOSP-DA E&M SIG COMPL 35 MIN	Follow up hospital visit 35 minutes
99238	4,440	HOSPITAL DISCHARGE DAY MANAGEMENT; 30 MINUTES OR LESS	Hospital discharge instructions to patients; 30 minutes or less
99242	889	OFFIC CONS NEW/ESTAB LOW 30 MIN	Office consultation 30 minutes
99243	11,944	OFFIC CONS NEW/ESTAB MOD 40 MIN	Office consultation 40 minutes
99244	10,007	OFFIC CONS NEW/ESTAB MOD-HI 60 MIN	Office consultation 60 minutes
Medicine - Hospital ER Services			
99282	12,730	EMERGENCY DEPT.VISIT W/EXPANDED PROB.FOCUSED HX+EXAM+MEDICAL DECISION MAKING OF LOW COMPLEXITY	Emergency room visit, low complexity
99283	29,303	ER Visit - Ed Pt L3 Exp Prob H&E Mod Complx	Emergency room visit, moderate complexity
99284	16,187	ER Visit - Ed Pt L4 Dtl H&E Mod Complx Dec	Emergency room visit, moderate complexity
99285	4,487	EMERGENCY DEPT.VISIT WITH COMPREHENSIVE HX+EXAM AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY	Emergency room visit, high complexity
Medicine - Preventive Care Visits			
99391	15,125	Preventive Care Visit - Est Pt Prevent/Healthy Under 1 Yr	Well child care under one year of age
99392	13,846	Preventive Care Visit - Est Pt Prevent/Healthy 1-4 Yrs	Well child care between one and four years of age
99393	9,483	Est Pt Prevent/Healthy Person 5-11 Years	Well child care, 5 to 11 years of age
99394	8,006	Preventive Care Visit - Est Pt Prevent/Healthy 12-17 Yrs	Adolescent preventive care, 12-17 years of age
99395	9,021	PREVEN MEDS E&M ESTAB PT; 18-39 YR	Preventive care, 18-39 years of age
99396	12,928	PREVEN MEDS E&M ESTAB PT; 40-64 YR	Preventive care, 40-64 years of age
Miscellaneous			
A4550	1,127	SURGICAL TRAYS	Charge for surgical tray
G0008	682	ADMIN FLU VIRUS VAC-NO MD FEE SCHED	Administration of influenza virus vaccine
G9001	5,398	COORDINATED CARE FEE, INITIAL RATE	COORDINATED CARE FEE, INITIAL RATE
H2000	5,092	COMPREHENSIVE MULTIDISCIPLINARY EVALUATION	COMPREHENSIVE MULTIDISCIPLINARY EVALUATION
J3420	713	INJ VITAMIN B-12 CYANOCOBALAMIN TO 1	Vitamin B 12 injection
Q0091	631	SCREEN PAP SMEAR OBTAIN PREP CONVEY	Screening pap smear
S4993	16,615	CONTRACEPTIVE PILLS FOR BIRTH CONTROL (ONE UNIT =	Birth control pills
T1015	5,170	CLINIC VISIT/ENCOUNTER ALL-INCLUSIVE (REPLACES HMO-COPAY AND RURAL HEALTH CLINICS CODES)	All inclusive clinic visit
Grand Total	1,150,568		